NEW YORK STATE | Commission of Correction

Final Report of the New York State Commission of Correction:

In the Matter of the Special Investigation into the Care and Treatment Provided to

India Cummings,
an inmate of the
Erie County Holding Center

June 26, 2018

To: Sheriff Timothy Howard
Erie County Holding Center
40 Delaware Avenue
Buffalo, New York 14202

Allen Riley
Chairman

Thomas J. Loughren
Commissioner

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(e), regarding the care and treatment provided to India Cummings which occurred while an inmate in the custody of the Erie County Sheriff at the Erie County Holding Center, the Commission has determined that the following final report be issued.

FINDINGS:

1. India Cummings was a 27-year-old female who died on 2/21/16 of acute renal failure that resulted in a cardiac arrest while at the Buffalo General Hospital. Cummings had been in the custody of the Erie County Sheriff at the Erie County Holding Center from 2/1/16 to 2/17/16 after her arrest by the Lackawana Police Department. Cummings was released from custody while hospitalized following a cardiac arrest that occurred at the Holding Center on 2/17/16. The Medical Review Board has found that the medical and mental health care provided to Cummings by Erie County during her course of incarceration and her care, custody, and safekeeping by Erie County Sheriff Deputies was so grossly incompetent and inadequate as to shock the conscience. Had Cummings received adequate and appropriate medical and mental health care and supervision and intervention from the beginning of her incarceration, her death would have been prevented. As Cummings' deteriorating health began after receiving traumatic injury to her arm during her arrest and then being subject to continued neglect during her incarceration, the Medical Review Board opines that her death should be ruled as a homicide due to medical neglect.

2. On 2/1/16, Lackawanna Police Officers were dispatched to assist the Lackawanna Fire Department on a mental health Emergency Medical Services (EMS) call. The Lackawanna Fire Chief reported that they were dispatched at 1:20 p.m. for an EMS call for an unconscious subject. Lackawanna Police Officers [redacted] responded to 62 Knowlton to assist the Fire Department. Cummings was reported to be acting disorderly. While the police were checking the back of the residence, Cummings ran out the front door and approached a vehicle waving her arms. The driver believed that Cummings needed assistance and rolled down the window. Cummings opened the car door, punched the driver in the nose, and forced the driver from the vehicle. Cummings then fled the scene with the vehicle. Police officers pursued Cummings. Cummings struck a vehicle and refused to stop despite police instruction. She then struck a school bus and again refused to stop. Cummings struck another vehicle that was stopped at a red light. Cummings' vehicle was stopped and she was commanded to exit the vehicle. She did not comply with the instructions to exit the vehicle. Officers used a baton to break the glass on the passenger side window of the vehicle. Cummings then tried to exit the vehicle on the driver's side. She was forced out of the vehicle, continued to behave in an irate and uncooperative manner, and refused to comply with the officer's directions. Cummings refused to put her hands behind her back and was then forced to the ground by police to be taken into custody. Cummings refused to be placed in the back of the police vehicle and attempted to kick the officers. Cummings was placed under arrest by the Lackawanna Police Department at approximately 2:17 p.m. During the transport to the Police Department Cummings continued to act in an unruly manner. Cummings was placed in a cell at the Lackawanna Police Department awaiting a 4:00 p.m. court arraignment. Cummings was arraigned by Judge F.M. and

was transported to the Holding Center at 4:28 p.m. Cummings bail was set at $15,000. Given Cummings erratic behavior at the scene and during her arrest, and based on that a call for emergency medical care was made on her behalf for altered mental status, the Medical Review Board opines that Cummings should have been transported to a hospital for evaluation prior to incarceration.

3. Cummings had no known medical history and was not prescribed any medications. She had no known mental health history or record of treatment in the community. Other than prior vehicle and traffic infractions, Cummings had no other known criminal history or police contact.

4. On 2/1/16 at 4:50 p.m., Cummings was admitted into the Holding Center. [redacted] The Medical Review Board finds that given her obvious mental status and lack of cooperation in the screening process, a Mental Health referral for ECMC would have been appropriate.

5. [redacted]

[redacted] The Medical Review Board finds that the discrepancy in the cause of the injury and the multiple car accidents prior to her arrest with the altered mental status should have alerted the ECMC medical staff to perform a further workup including a chest x-ray and Mental Health referral. While Cummings was being transported from ECMC to the Holding Center she had an altercation with the deputies and bit one of them. Cummings also refused to get into the patrol car and was combative. Cummings was charged with Disorderly Conduct, Harassment 2nd Degree, and Obstructing Governmental Administration 2nd Degree.

6. On 2/2/16, per the Holding Center Booking log book, Cummings returned to the Holding Center at 2:45 a.m. Per the Alpha Long log book, at 3:09 a.m., Cummings was placed into Alpha Long cell #18. [redacted]

7. [redacted]

8. [redacted]

[redacted] The Medical Review Board finds that the lack of examination of Cummings' injury and the lack of documentation was grossly negligent medical care.

9. On 2/2/16 from 9:10 p.m. until 10:10 p.m., Cummings had a contact visit with [redacted] This was the only visit Cummings attended. On 2/8/16, 2/9/16, and 2/10/16, Cummings refused her visits and would not comply with directions to get dressed for a visit. There was no documentation in the Delta Control logbook of her refusal of the visit on 2/10/16. This refusal was located on the visitation log.

10. [redacted] At 10:10 a.m., per the Alpha log book, Cummings was designated "A/P Ad seg and was Dep/Sup cuffed." This meant that Cummings was on Administrative Segregation and was required to be handcuffed and transported with a Deputy and a Supervisor present. [redacted] The Medical Review Board finds that the finding of elevated blood pressure at the ECMC and the Holding Center should have prompted an order for monitoring with vital signs more checked more frequently.

11. On 2/3/16, following Cummings' assault incident with staff, her classification was not reviewed. Commission staff interviewed facility staff and reviewed classification records and noted that Cummings' classification was not reviewed as required by 9 NYCRR §7013.9. Pursuant to 9 NYCRR §7013.9 (a)(1), an inmate's classification status shall be

reviewed and revised as necessary if the inmate is involved in a serious unusual incident or exhibits adjustment problems which threaten her safety or the safety, security, or good order of the facility. Cummings was involved in several serious events that met the criteria outlined within the Standard including the assault on staff incident that occurred on 2/3/16. This is a violation of 9 NYCRR §7013.9 (a)(1) Classification Review.

12. Commission staff interviewed facility staff and reviewed facility records and noted that on 2/3/16, Cummings was involved in an assault on personnel that resulted in injuries to a facility staff member. Pursuant to 9 NYCRR §7022.3(a)(2), this incident should have been reported to the Commission within 24 hours of occurrence or discovery. The failure to report this incident constitutes a violation of 9 NYCRR §7022.3 (a)(2) Reportable Incidents. Cummings was charged with Assault: Intentionally Inflicting Physical Injury Upon a Staff Member, Disorderly Conduct- that results in injury or threatens the safety, security, or order of the facility, Harassment, and Failure to Obey Any Order from Staff Immediately. Per the disciplinary report, Cummings struck one deputy in the jaw and caused cuts and scratches to another deputy.

13. [redacted] The Medical Review Board finds that given Cummings' documented presentation, an immediate psychiatric referral should have been made. Additionally, the Medical Review Board finds that LMHC [redacted] failed to properly inform the Erie County Holding Center staff of her condition and questions the clinical decision as to how if Cummings was documented as "not oriented to place or time" how could she function in general population with other inmates.

14. On 2/4/16, Cummings was arrested for Assault on a Police Officer/Fireman/EMT, Assault 2nd Degree, Assault 3rd Degree, and Obstructing Government Administration 2nd Degree due to the incident that occurred on 2/3/16. Following her arrest, Cummings' classification was not reviewed. This is a violation of 9 NYCRR §7013.9 (a)(1) Classification Review.

15. [redacted]

[redacted] The Medical Review Board opines that had Cummings been seen in a timely manner when the records were obtained and examined by a physician, her serious medical conditions could have been identified and treated.

16. On 2/4/16 at 6:31 p.m., per the Alpha Seg log book, maintenance was on the unit to check Cummings' sink in her cell. "Cummings refused to push the sink button. Maintenance left the unit." was documented in the logbook. There was no indication in the log book of a problem with the sink.

17. On 2/5/16 at 9:55 a.m., per the Alpha Seg log, book Cummings was brought to Lackawanna City Court and returned at 11:35 a.m. Per the transcript of the court appearance, Cummings was to undergo a 730 examination prior to being indicted. This request came from Judge N.L. and was requested to be completed prior to her return to court date of 2/24/16. Cummings was represented by assigned attorney J.K.

18. [redacted] The Director stated that it could take one to two weeks as a 730 examination required two psychiatrists to complete. During an interview with Commission staff, Dr. [redacted] stated that a 730 examination can be completed by a psychiatrist or psychologist. In February 2016, the Erie County Forensic Mental Health had two psychiatrists and three psychologists on staff that could do the 730 examinations. Dr. [redacted] stated that it usually takes approximately two weeks to complete and [redacted] The Medical Review Board finds that Erie County Forensic Mental Health failed to properly initiate and expedite a competency evaluation on Cummings.

19. [redacted]

[redacted]

20. The Holding Center has an Interdisciplinary team that meets daily to discuss those inmates who are on observation, have behavior problems, are on meal monitoring, or refusing medications. The members of the team include an RN, a sergeant, and a mental health staff member. [redacted] The reports from the meeting are emailed to a specified list of recipients to include other medical staff and mental health staff as well as security staff. However, during the investigation, Dr. [redacted] stated that he does not receive the Interdisciplinary Team report minutes and it was also discovered that this report is not emailed to the facility medical director or the other psychiatric providers. Dr. [redacted] is the only psychiatrist who receives the report. The Medical Review Board finds that the lack of communication among the mental health staff and the lack of information available to mental health staff hinders the comprehensive psychiatric care that is required for comprehensive mental health care.

21. On 2/5/16 at 4:25 p.m., per the Alpha Seg log book, Cummings was allowed time out of her cell and was returned at 4:45 p.m. During an interview with Commission staff, Deputy [redacted] stated that this indicated the time Cummings was allowed out of her cell for shower access and phone use.

22. On 2/5/16 at 4:50 p.m., per the Delta Female Control log book, Cummings was moved to the unit in cell 87 and was "Dep/Sup" (supervised escort). At 7:39 p.m. and 9:45 p.m., there was documentation in the Delta Control log book of the LPN doing medications with no refusals indicated. [redacted] This is a violation of the Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication

Management Medication Administration ECSO CHD: 11-01-00 which states:
a- the inmate will refuse medication face to face with the nurse and report the rationale for refusal,
b- all inmate medications refusals will be documented within the EMAR,
c- the nurse assigned to passing medications is responsible for notifying the medical or FMH provider via the EMR, when a medication is missed for three (3) consecutive doses, or missed 50% of the scheduled doses in a one-week period.
d- the inmate refusing medication will sign a medical refusal form, the signed refusal form will be signed by two medical staff members and scanned into the inmates EMAR,
e- if the inmate refuses to sign the form, the form will be witnessed as to refusal to sign and scanned into the EMAR, and
f- at the time of refusal the nurse will educate the inmate about potential health risks for refusing medication, worsening of symptoms, consequences of refusal of medical treatment.

In the case of psychiatric medications, this refusal will be reported to the mental health staff during the morning interdisciplinary team meeting. The lack of documentation regarding Cummings' refusal of medication is a violation of Erie County Department of Health (ECDOH) Correctional Health (CH) Medication Delivery System ECDOH CH-06.04.00, as this was not noted at the Interdisciplinary Team meeting.

In a response to the Commission's preliminary report dated 5/30/18, the Erie County Attorney reported that policy ECSO CHD: 11-01-00 from 2015 supersedes policy ECDOH CH-06.04.00 and does not identify any reporting requirement to the interdisciplinary team meeting for refused medications. Both policies were provided to the Commission during the review of the matter with no indication that ECDOH CH-06.04.00 was not in effect.

23. On 2/6/16, per the Delta Control log book, the nurse was on the unit at 7:50 p.m. for medications and there is no indication of any refusals. [redacted]

24. On 2/7/16 at 11:15 a.m., per the Delta Control log book, Cummings refused her meal. At 1:25 p.m., Cummings was observed flooding her cell and the water was shut off. Sergeant [redacted] documented in the Delta Control logbook that water usage was to be monitored, used, and then turned off. During an interview with Commission staff, Deputy [redacted] stated that Cummings had been splashing water on herself earlier in the shift. When there was water noted to be coming under the door the supervisor was called and advised to come to the unit. Deputy [redacted] stated that after the water had been turned off, the sergeant later returned and stated that the water could not be shut off and would just be monitored. Following this individual inmate disturbance, Cummings' classification was not reviewed. This is a violation of 9 NYCRR §7013.9 (a)(1) Classification Review.

25. Commission staff interviewed facility staff and reviewed the Delta Control log book entries for 2/7/16. Commission staff noted an entry authored by Sergeant [redacted] documenting an event involving Cummings who was flooding the housing area and ordered "water usage to be monitored, used and then turned off". The next logbook entry regarding Cummings' water use was entered on 2/11/16 at 7:30 a.m., indicating "Inmate asking for water, water on. Flood dodgers in place Inmate Cummings prone to flood." Commission staff was advised during an interview with Chief of Operations [redacted] that he was unaware that the water was shut off to Cummings' cell and that the Watch

Commander maintained the authority to approve water deprivation and that it should have been documented via an administrative deprivation order. Further interviews with Captain [redacted] (Watch Commander) and Sergeant [redacted] (Area Supervisor) indicated that the Area Supervisor maintained the authority to shut off water to an inmate's cell and higher approval was not needed. Sergeant [redacted] further advised Commission staff that it is incumbent upon his relief to either continue or discontinue the "water monitoring". Sergeant [redacted] advised Commission staff that the toilet and sink in the cell maintained separate shut off valves and that his order to turn the water off applied only to the toilet; the sink remained functional. Commission staff toured the housing area with Captain [redacted] visually inspected the plumbing chase, and noted that there was only one water shut off valve controlling water to both the sink and toilet. There was no documentation of any administrative orders issued to restrict Cummings access to her cell water other than the logbook entry dated 2/7/16. Additionally, from 2/7/16 at 1:25 p.m. to 2/11/16 at 7:30 a.m., there was no clear indication of what time periods Cummings had her access to the water in her cell turned on or off. A restriction of water to a cell, absent a clearly documented need for the safety and security of the facility with administrative review and approval, constitutes a violation of 9 NYCRR §7040.4(b)(2) & (3) Individual Occupancy Housing Units. Each individual occupancy housing unit shall contain: (1) one bed and mattress, (2) one functional sink, and (3) one functional toilet.

In a response to the Commission's preliminary report dated 5/30/18, the Erie County Attorney provided documentation that there were separate shut off valves for both the cell sink and toilet in addition to a main water shut off vavle. A photo provided of the water valve assembly in the plumbing chase area shows separate valves labeled on the photo for both the sink and the toilet with a main water shut off valve located below them. The individual valves shown have slotted top fittings with no attached handles. These type valves would require the use of a tool or key to be effectively shut off. There was no documentation provided to indicate that either maintenance was called or a tool obtained to shut the water off, as ordered on 2/7/16, or turned on, as entered in the logbook on 2/11/16.

26. On 2/7/16 during the 3:00 p.m. to 11:00 p.m. shift, Deputy [redacted] noted that at 3:00 p.m. Cummings had ripped up the vinyl part of the mattress during the previous shift and that the sergeant was to be notified. There was no documentation in the log book to indicate that Cummings had ripped the mattress on the previous shift. At 8:46 p.m. per the Delta Control log book, the LPN was on the unit for medications and there were no refusals for medications noted. [redacted] This is a violation of the Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00. During an interview with Commission staff, Deputy [redacted] could not recall the sergeant's response to the ripped mattress. When asked if there was water on in Cummings' cell, Deputy [redacted] stated that he could not recall the water being off. Deputy [redacted] stated that he did not issue a misbehavior report to Cummings for damaging the mattress. During an interview with Commission staff, Sergeant [redacted] stated that the water was on in Cummings' cell on his tour. Sergeant [redacted] stated that he does not leave the water off in cells. The failure to replace the ripped mattress which would be deemed non-serviceable is a violation of 9 NYCRR §7040.4(b)(1) Individual Occupancy Housing Units. Pursuant to 9 NYCRR §7040.4(b)(1), each individual occupancy housing unit shall contain one bed and mattress. There was no documentation of any administrative deprivation orders issued to deprive Cummings of her entitlement to possess a mattress.

27. On 2/8/16 at 7:36 a.m., per Deputy [redacted] in the Delta Female log book, Cummings refused to go to her disciplinary hearing. A review of the disciplinary report indicated that Cummings received sanctions including restitution of $100, loss of 1-hour visit for 120 days, disciplinary segregation for 180 days, and full restriction. At 7:56 a.m., Sergeant [redacted] was on supervisory rounds. At 8:15 a.m., per the Delta Female log book, Cummings refused her Orthopedic appointment. Cummings refused to sign the transportation refusal form which was signed by the deputy. Cummings also refused court on this date. At 1:02 p.m., Cummings refused a visit. At 1:25 p.m., Sergeant [redacted] was on supervisory rounds. There was no indication in the log book that these refusals were addressed by the sergeant or that the sergeant spoke to Cummings. During an interview with Commission staff, Deputy [redacted] stated that all refusals are obtained by the Supervisory staff. During an interview with Commission staff, Sergeant [redacted] stated that the deputy obtains the refusals and notifies the appropriate areas. Sergeant [redacted] stated that the supervisor goes up to the housing unit for the escort once the deputy confirms the inmate is going to the appointment. Sergeant [redacted] stated that he does not see every inmate when he is on his supervisory rounds. The Medical Review Board finds that this discrepancy regarding who obtains the refusals is indicative of the systemic management failures of the Holding Center.

28. On 2/8/16 at 7:47 p.m., per the Delta Control log book, the LPN was on the unit for medications and there was no indication that Cummings had refused her medications. [redacted] This is a violation of the Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00.

29. On 2/9/16 during the 11:00 p.m. to 7:00 a.m. shift, per the Delta Female log book, Cummings mattress was ripped, the stuffing was pulled out, and room was in disarray as noted in the previous log. There is no indication in the log book that Cummings' mattress was replaced. The failure to replace the ripped mattress which would be deemed non-serviceable is a violation of 9 NYCRR §7040.4 (b)(1) Individual Occupancy Housing Units.

30. On 2/9/16 at 9:40 a.m. per the Delta Female log book, Cummings was out to Buffalo City Court. This was for an arraignment for Assault on a Police Officer/Fireman/EMT, Assault 2nd Degree, Assault 3rd Degree and Obstructing Government Administration 2nd Degree. At 9:55 a.m., per the log book, maintenance was on the unit to clean Cummings' cell. At 10:13 a.m., Cummings returned from court. At 1:17 p.m., Deputy [redacted] documented in the Delta log book that Cummings refused a non-contact visit. During an interview with Commission staff, Deputy. [redacted] stated that Cummings was urinating on the floor and was not showering. Deputy [redacted] stated that it is common to have the cells cleaned when the inmates are out of the cell.

31. On 2/9/16, a second separate request for a competency evaluation was received from Judge G. at Buffalo City Court. This was the second request for a 730-competency evaluation issued by a court for Cummings. Mental Health requested additional time to complete the evaluation as the adjournment date was 2/16/16. Mental Health Director [redacted] stated that they usually take one to two weeks to complete. The Medical Review Board finds that Erie County Forensic Mental Health again failed to properly initiate and expedite a 730 competency exam, that was indicated as needed by two separate court jurisdictions.

32. On 2/9/16 at 7:24 p.m. per the Delta Female log book, the LPN was on the unit for medications. There is no indication of refusals noted in the log book. [redacted] This is a violation of the Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00.

33. [redacted] The Medical Review Board opines that Cummings, who was documented as impaired enough to be unable to sign for a release of her privacy information, was not of a sound state of mind to be incarcerated and required immediate physician intervention and hospitalization.

34. On 2/10/16 at 7:24 p.m., per the Delta Control log book, the LPN was on the unit for medications and there is no indication of any refusals. [redacted] This is a violation of the Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00.

35. On 2/11/16 at 1:20 a.m., per the Delta Control log book, Deputy [redacted] stated that Cummings was pounding on her door yelling for help. Cummings stated that she needed to go downstairs and get out of there. Cummings was told the time and then Cummings said that she couldn't breathe. Per the log book entry, Sergeant [redacted] was notified and there was no indication of any action being taken. At 6:15 a.m., Sergeant [redacted] was on the unit for supervisory rounds without any indication of Cummings being seen. During an interview with Commission staff, Deputy [redacted] stated that Cummings stated that she wanted to go home and when she was told she couldn't leave, she then stated that she couldn't breathe. Deputy [redacted] stated that the sergeant informed him that he would follow up with medical. Deputy [redacted] stated that an LPN came up later in the shift to deliver medications, but he could not recall if Cummings was seen. Deputy [redacted] stated that Cummings slept for the remainder of the shift and was not in any distress. The Delta Control log book documented that the LPN was on the unit at 4:59 a.m. for medication. There was no indication that the LPN saw Cummings. During an interview with Commission staff, Sergeant [redacted] stated that he did not recall being told of Cummings' complaints and that he would have called medical to have medical come see her. He stated that he did not recall medical coming to see her that shift. Sergeant [redacted] then stated that he was unsure if she went to medical or if medical came to see her.

36. On 2/11/16 at 7:30 a.m. per the Delta Control log book, Deputy [redacted] noted that Cummings was asking for water and documented "water on, flood dodges in place, inmate prone to flooding." At 8:18 a.m., Cummings was offered recreation but refused. During an interview with Commission staff, Deputy [redacted] stated that Cummings had a mattress in her cell. Deputy [redacted] stated that she could not recall Cummings' behaviors or the condition of her cell. When asked about the water request, Deputy [redacted] stated

that at times Cummings was unable to push the button for water on her sink but that there was water access in her cell. There was no other documentation of flood dodges noted on any other log book entries. On 2/11/16, the Holding Center administration received a call from the sergeant at court who stated that Cummings was mentally decompensating and needed to be seen. [redacted] Per Mental Health Specialist J.L., this is a meeting about medications and problems with patient's medications. The meeting does not address specific inmates. During an interview with Commission staff, Sergeant [redacted] stated that he called medical and reported that Cummings appeared disheveled and with a flat affect. Sergeant [redacted] attempted to talk to Cummings at court but she would not engage him. Sergeant [redacted] stated that he was quite concerned about her presentation and he contacted the facility medical department with his concerns and was advised that they were going to a meeting and would address his concerns there.

37. [redacted]

38. [redacted] During an interview with Commission staff, Dr. [redacted] stated that she does get notified if inmates refuse medications in general, as the medical department notifies the counselor. After three refusals, an appointment is scheduled with the provider to assess and review. [redacted] Dr. [redacted] did state that medications compliance can be seen in the electronic medical records by the providers. [redacted] Dr. [redacted] stated that if an inmate is referred for a 9Z2 (forensic

mental health) bed the referral is also verbal and handled by Mental Health Director [redacted] who maintains a list and triages to place inmates as needed. A 9Z2 bed is an inpatient mental health bed at the Erie County Medical Center that can provide a higher level of psychiatric inpatient care. There are two beds available in this unit for county inmates. [redacted] Dr. [redacted] stated that other than the two forensic mental health beds available at ECMC on the 9Z2 unit, the county has no other options for psychiatric beds for an inpatient stay. The Medical Review Board finds that this was an abject failure by the psychiatric provider to take immediate action on a floridly decompensating patient in need of urgent medical and psychiatric intervention. The Board opines that the psychiatrist had an absolute duty to assure that Cummings was referred to medical by having a physician to physician consultation instead of delivering said request to nursing staff at the facility. The failure of Dr. [redacted] to take appropriate action in this matter at this critical juncture continued the cascade of failures that led to Cummings' death and in the Board's opinion, is evidence of negligent medical care.

39. On 2/11/16 at 5:00 p.m. per the Delta Control log book, Deputy [redacted] documented that Cummings refused medical. During an interview with Commission staff, Deputy [redacted] stated that he did not recall what Cummings refused. Deputy [redacted] stated that the inmates can be called through the speaker in their cell and would be told that medical is there to see them. Through this speaker, the inmate can say yes or no to being seen. Deputy [redacted] also stated that if an inmate needs something from medical there is a call box in the room that alerts the control room and then they can call medical. [redacted] There was still no treatment for Cummings' fractured arm and she was not noted to be wearing a brace. There was no refusal noted in the medical record for the assessment and vital signs for Cummings. This is a violation of Erie County Department of Health (ECDOH) Correctional Health (CH) Refusal of Care ECDOC CH-02-09-00 (Policy #12-07-00) which requires the completion of a Refusal of Recommended Treatment Form. There is no evidence of Cummings being notified of the consequences of the refusal. This was the last RN documentation in the medical record of any attempt at an assessment, vital signs, or care. The RN's grossly inadequate assessment from outside the cell and their lack of intervention on Cummings behalf were negligent and constituted professional misconduct. The Medical Review Board opines that the medical staff failed to pursue additional attempts to complete an assessment or to refer Cummings to a higher level of care which resulted in Cummings not receiving appropriate medical intervention and ultimately her death. Pursuant to 9 NYCRR §7010.1(b) prompt screening is essential to identify serious or life-threatening medical conditions requiring immediate evaluation and treatment.

40. On 2/11/16 at 6:25 p.m., per the Delta Female one to one observation log book, the post was opened with Deputy [redacted] and the reason for the one to one observation was not documented. This is a violation of 9 NYCRR §7003.3(j)(5)(i) Supervision of Prisoners. Commission staff reviewed Constant Observation logbook entries and noted that facility staff failed to document within the logbook the reasons that Cummings was placed on additional supervision. Pursuant to 9 NYCRR §7003.3(j)(5)(i), this information is required to be documented within the written supervision records and the failure to do so constitutes a violation of this section.

41. [redacted]

During an interview with Commission staff, Deputy [redacted] stated that Cummings was very clear and coherent when she refused her medications. This is a violation of Erie County Department of Health (ECDOH) Correctional Health (CH) Refusal of Care ECDOC CH-02-09-00 (Policy #12-07-00) as there was no refusal form or education noted.

42. At 7:35 p.m., the meal monitoring tool was on the unit. [redacted] There was no doctor or provider order written for the meal monitoring. There is no indication of the doctor being consulted or notified of the meal monitoring. There is no evidence of a provider appointment being made for an evaluation. This is a violation of 9 NYCRR §7010.2 which states "no medication or medical treatment shall be dispensed to an inmate except as authorized or prescribed by the facility physician." This is also a violation of Erie County Department of Health (ECDOH) Correctional Health (CH) Meal Monitoring ECDOH CH-06.10.00 (Policy #12-10-00). When security staff becomes aware that an inmate is not eating regularly and such irregularity consists of three or more consecutive meals, the security staff member will make an entry into the housing area log book documenting this observation and notify medical. Following notification, the inmate will be examined in the medical unit. If appropriate, the medical provider will order a meal monitoring plan to be started. A full physical workup will be conducted. The inmate will be scheduled for daily weights, vital signs, and a nursing assessment of orientation and mental status. The nurse will notify the medical provider of any decrease in weight, signs of dehydration, or changed in mental status. This was also a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01 which adds that the assessment will include but not limited to all the above and skin turgor and mucous membranes. All documentation will be in the inmate's electronic medical records (EMR). The Medical Review Board finds that the lack of RN assessments and physician evaluation is indicative of the grossly negligent care that was provided to Cummings during her incarceration and contributed to her death.

43. [redacted]

[redacted]

44. On 2/12/16 on the 11:00 p.m. to 7:00 a.m. shift, per the Delta log book, Deputy [redacted] documented that Cummings was on a one to one and Deputy [redacted] was sitting with her. There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3 (j)(5)(i)-Supervision of Prisoners. At 4:15 a.m., Cummings was noted as washing her shirt at the sink. The deputy noted that she called for a new shirt from the linen room. At 4:30 a.m., Cummings was noted to be drinking water. At 4:40 a.m., Cummings was offered to exchange the wet shirt for a dry shirt and she refused. At 5:30 a.m., Cummings was given breakfast and per the meal monitoring tool, Cummings did not eat. During an interview with Commission staff, Deputy [redacted] stated that initially Cummings refused to exchange the shirt, but then did switch the shirt out. Deputy [redacted] stated that Cummings' toilet was shut off but her water was on in her cell. There is no indication in the log book of Cummings urinating. Commission staff reviewed the Constant Observation logbook entries and interviewed facility staff responsible for supervising inmates on constant observation. Commission staff noted that the facility's practice consisted of documenting observations and inmate activity at set 15-minute intervals and any inmate activity that occurred during the intervals was not documented. Pursuant to 9 NYCRR §7003.3(j)(5)(vi), logbook records shall include periodic facility staff observations of the prisoner's condition or behavior. The Commission's interpretation of this standard deems that all inmate activity shall be documented and in instances where there is no change in activity or behavior, such as when the prisoner is asleep, then an entry should be made documenting the prisoner's continued activity at intervals not to exceed 15 minutes. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners.

45. On 2/12/16 on the 7:00 a.m. to 3:00 p.m. shift, per the Delta female one to one log book, it was noted by Deputy [redacted] "at 7:00 a.m. Cummings was walking around naked banging on the door saying, 'let me out'." There is no indication of the reason for the one to one which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 7:15 a.m., Cummings was turning the sink on and off. At 10:30 am, Cummings was laying on her bunk complaining but there was no indication of what the complaints were in the log book. At 11:25 a.m., lunch was served on the unit and per the meal monitoring tool, Cummings refused her tray and did not eat. At 2:45 p.m., Cummings was spitting water on the floor. There is no indication that Cummings urinated during this eight-hour shift. This is a violation of 9 NYCRR §7003.3(j)(5)(vi). At this time per the one to one log book, Cummings had not urinated in 16 hours, a critical finding indicating possible dehydration and renal malfunction that needed to be immediately reported to medical staff. During an interview with Commission staff, Deputy [redacted] stated that Cummings "seemed out of it, didn't act like she knew she was in jail."

46. [redacted]

47. [redacted] During an interview with Commission staff, Sergeant [redacted] stated that the meetings were about 15 minutes long and they would discuss medication noncompliance, any inmates on observation, and inmates having incidents or behaviors. The report is emailed through a chain of command to medical, mental health, and security staff. This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01 which states that "the interdisciplinary team will discuss each inmate being followed for meal monitoring of any concern or change in condition." There is no indication that this was discussed by the team and there is no documentation on the report that Cummings was on a meal monitoring. Per Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Hunger Strike ECSO CHD:05-07-00 Procedure: 2- the nurse will place the inmate on a meal monitoring tool. The monitoring tool will be assessed daily by the registered nurse and documented within the medical record. There is no evidence of an RN going on the unit for an assessment for the 7:00 a.m. to 3:00 p.m. shift and there is no indication in the one to one log book that an RN was in to see Cummings.

48. On 2/12/16 during the 3:00 p.m. to 11:00 p.m. shift, Deputy [redacted] was assigned the 2 to 1 observation. There was no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 4:45 p.m., Cummings returned her old meal tray and was given dinner. Per the meal monitoring tool, Cummings did not eat food but did drink lemonade. At 5:00 p.m., Cummings asked to clean up and was told that the deputy would check with the sergeant. Deputy [redacted] documented that "I/M is a dep, sup, cuffed I was told for transport within a facility." At 6:45 p.m., Cummings was given soap and a towel to wash in her cell. At 7:00 p.m., Cummings was noted to be brushing her teeth. At 7:15 p.m., Cummings was given a blanket for her bunk. There is documentation in the Delta Female Control book and the Delta Female 2 to 1 observation log book that the nurse was on the unit for medications at 7:45 p.m. and [redacted] At 8:00 p.m., Cummings was

issued six pairs of socks, two bras, and six pair of underwear from the "ground floor". At 9:30 p.m., there was a notation that Cummings was sleeping on her bunk. There was a late entry that noted "mattress was brought up by maintenance and was not given to Cummings today, wait to see if behaviors continue to improve so this one is not destroyed. Has been cooperative with all directions given by sergeant and deputy this shift." There is no indication of an RN coming to see Cummings to assess her or to review the meal monitoring tool. There is no indication that Cummings urinated. This shift marks 24 hours that Cummings had not been documented while on constant supervision as having urinated, a critical finding indicating possible dehydration and renal malfunction that needed to be immediately reported to medical staff. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners.

49. During an interview with Commission staff, Deputy [redacted] could not recall if Cummings was issued the new mattress. Deputy [redacted] also could not recall why Cummings was issued new clothing during the 3:00 p.m. to 11:00 p.m. shift. During an interview with Commission staff, Sergeant [redacted] stated that Cummings requested shower access but could not be allowed when she requested it as the facility locks down from 5:30 p.m. to 6:30 p.m. When he returned to offer her the shower after lockdown at approximately 6:45 p.m., Cummings refused at that time. When asked about the clothing that was issued to her, Sergeant [redacted] stated that this would have been property brought in by family and is usually issued at this time. Sergeant [redacted] stated that he never told the deputy not to give Cummings the mattress when it was brought up. He did state that Cummings had water in her cell. There is no indication that Cummings urinated. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners. Cummings was not afforded a shower on this shift after her request. It is further noted that at 9:30 p.m., Deputy [redacted] documented that Cummings "has been cooperative and complied with all directions" issued by the deputy and the sergeant "on this shift". Commission staff was advised by Holding Center staff that when inmates are transferred between housing units, they do not transfer facility issued property with them and are reissued property in the new housing assignment. Commission staff reviewed the Constant Observation logbook entries for Cummings and noted that on 2/12/16 at approximately 6:45 p.m., Deputy [redacted] issued Cummings a towel and soap to wash up in her cell. Further, at approximately 7:15 p.m. she was issued a blanket and at approximately 8:00 p.m. She was issued undergarments, including six pairs of white socks, two bras, and six pairs of underwear. There is no documentation of any administrative deprivation orders issued to deprive Cummings of her entitlement to possess a towel, blanket, and clothing/undergarments. Cummings was transferred to Delta Female cell 87, on Administrative Segregation and subsequently disciplinary status, on 2/5/16 at approximately 4:50 p.m. This prolonged deprivation constitutes violations of 9 NYCRR §7005.6(a)(6)- Personal Health Care Items, §7005.7- Clothing, and §7005.9(a)-Bedding.

50. On 2/13/16, on the 11:00 p.m. to 7:00 a.m. shift, Cummings was supervised by Deputy [redacted] There was no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i) Supervision of Prisoners. At 4:15 a.m., Cummings was standing at the sink with her head underwater while she was urinating on the floor. At 5:27 a.m., Cummings was given her breakfast tray. Cummings took the juice and then threw the tray on the floor yelling "I don't fucking want it." Cummings then began yelling to let her out. During an interview with Commission staff, Deputy [redacted] was unable to recall if the supervisor was notified of this behavior. Deputy [redacted] did state that

when a supervisor makes his rounds, he is given an overview of the inmate's behaviors. During an interview with Commission staff, Sergeant [redacted] stated that he did not recall if he was notified of Cummings' behavior that shift. Sergeant [redacted] stated that when he is on duty during the first round he reviews the log book and on subsequent rounds he relies on the deputies to tell him about any changes. Upon review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. The facility failed to take reasonable action to ensure that Cummings' cell remained in a habitable condition. The inaction of facility staff, allowing the cell to degrade to a deplorable condition, constitutes a violation of 9 NYCRR §7015.2(c)-Cell Sanitation. This is a violation of NYS Correction Law §500 – K Treatment of Inmates and Correction Law §137 (6)(b) which requires that: Adequate sanitary and other conditions are required for the health of the inmate shall be maintained.

51. On 2/13/16 during the 7:00 a.m. to 3:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i) Supervision of Prisoners. At 10:15 a.m., Cummings was standing at the door and observed urinating on the floor. At 11:30 a.m., Cummings was noted to be drinking water. Per the meal monitoring tool, Cummings ate an orange and drank milk. Upon review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2(c)-Cell Sanitation. During an interview with Commission staff, there were no changes in her behavior per Deputy [redacted] On the 7:00 a.m. to 3:00 p.m. shift, there was no indication in the one to one observation log book that an RN was in to see Cummings or to review the meal monitoring tool as was required per policy.

52. [redacted] There is no indication these findings were relayed to the Psychiatrist, jail physician, or medical staff. The Medical Review Board opines that this lack of communication and failure to obtain care for an inmate in an obvious declining mental and physical status further expedited her continued decline that led to her death.

53. [redacted] There is no

indication on the report that Cummings was on meal monitoring or that she was refusing medications. This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01.

54. On 2/13/16 on the 3:00 p.m. to 11:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 4:35 p.m., Cummings refused her meal and accepted her juice. At 8:15 p.m., Cummings was observed sitting in front of the cell door "peeing." [redacted] Upon review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2 (c) Cell Sanitation. This is a violation of NYS Correction Law §500 – K Treatment of Inmates and Correction Law §137 (6)(b). During an interview with Commission staff, Deputy [redacted] reported that Cummings was naked the whole time, talking to herself, hard to understand, and babbling. Deputy [redacted] reported that Cummings had a mattress and was given a smock and smock blanket. Per Deputy [redacted] when the LPN came with medications, Cummings expressed that she did not want medications. Deputy [redacted] reported that urine came out of the cell door but she was unable to recall who cleaned it up. There is no indication in the one to one observation logbook that an RN was in to see Cummings.

55. On 2/14/16 on the 11:00 p.m. to 7:00 a.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3 (j)(5)(i) Supervision of Prisoners. Cummings was reported to be naked all night, laying down on the floor or bunk, and occasionally moaning. At 2:30 a.m., Cummings was laying on the floor moaning and ripping up her cup, naked. At 5:30 a.m., Cummings refused breakfast and per the meal monitoring tool consumed only juice. At 6:45 a.m., Cummings was laying on the floor and urinated all over herself and remained naked. Upon review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2 (c) Cell Sanitation. This is also violation of NYS Correction Law §500 – K Treatment of Inmates and Correction Law §137 (6)(b). During an interview with Commission staff, Deputy [redacted] stated that Cummings frequently made moaning noise. Deputy [redacted] did not note any changes in Cummings' mood or behaviors from her previous time with her. Deputy. [redacted] stated that the sergeant was notified of Cummings urinating on herself and was told that they were aware of this issue.

56. On 2/14/16 on the 7:00 a.m. to 3:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. Cummings was lying on the floor or bunk until 11:45 a.m., when she was noted to be on the floor eating lunch. Cummings then remained laying on her bunk until the end of the shift. On the 7:00 a.m. to 3:00 p.m. shift, there is no indication in the one to one observation log book that an RN was in to see Cummings as required per the meal monitoring policy. There is no indication that Cummings had urinated. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners.

57. [redacted] There was no evidence that Mental Health Specialist I [redacted]s inability to assess Cummings or her observations were referred to the psychiatrist.

58. [redacted] There was no indication on the report that Cummings was on meal monitoring, refusing medication, and decompensating. This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-0.

59. On 2/14/16 on the 3:00 p.m. to 11:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i) Supervision of Prisoners. Cummings was documented as remaining naked and moaning. At 4:30 p.m., dinner was served and per the meal monitoring tool, Cummings accepted her tray but consumed only juice. [redacted] There was no progress note or refusal form signed. This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00. On the 3:00 p.m. to 11:00 p.m. shift, there was no indication in the one to one observation log book that an RN was in to see Cummings to assess her or review the meal monitoring form. Deputy [redacted] remained for the 11:00 p.m. to 7:00 a.m. shift. At 11:00 p.m., Cummings was observed laying naked in her food on the floor. At 1:14 a.m., Sergeant [redacted] was on the unit for rounds and Cummings refused to wear clothes and had trash and clutter all over her cell floor. Upon review of the Constant Observation log book, there was no evidence that Cummings had cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2(c)-Cell Sanitation. This is a violation of NYS Correction Law §500 – K Treatment of Inmates and Correction Law §137 (6)(b). At 5:12 a.m., Sergeant [redacted] returned and noted that Cummings continued to refuse to get dressed or cleaned and noted that the cell needed a thorough cleaning. There was no indication of action being taken by the deputy or the sergeant. At 5:34 a.m., Cummings refused her meal tray and did not eat per the meal monitoring tool. At 6:45 a.m., Cummings was documented as laying on the floor under her blanket. During the 3:00 p.m. to 11:00 p.m. and the 11:00 p.m. to 7:00 a.m. shift, there was no indication that Cummings had urinated a critical finding indicating possible dehydration and renal malfunction that needed to be immediately reported to medical staff. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3 (j)(5)(vi) Supervision of Prisoners. During an interview with Commission staff, Deputy [redacted] stated that she does review log books from the previous shifts when she assumes her post. Deputy [redacted] stated that she would not have documented urination unless Cummings did so on her 15-minute documentation time.

60. On 2/15/16 for the 7:00 a.m. to 3:00 p.m. shift, Cummings was supervised by Deputy [redacted] There was no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3 (j)(5)(i) Supervision of Prisoners. At 7:00 a.m.,

Cummings was noted to be on the floor naked with food and a tray scattered around the cell. Upon a review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2(c)-Cell Sanitation. This is a violation of NYS Correction Law §500 – K Treatment of Inmates and Correction Law §137 (6)(b). Cummings refused her lunch tray at 11:15 a.m. Cumming spent the remainder of the shift laying on the floor or her bunk making noises and sleeping. At 12:20 p.m., a pass-through key was added to the key ring. During an interview with Commission staff, Deputy [redacted] stated that the feed up flap is generally left open and this key was added so that the flap could be opened if it got closed. On the 7:00 a.m. to 3:00 p.m. shift, there was no indication in the one to one log book that an RN was in to see Cummings. There is no indication in the one to one log book that Cummings urinated. This shift marks 24 hours that Cummings had not been observed having urinated, a critical finding indicating possible dehydration and renal malfunction that needed to be immediately reported to medical staff. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3 (j)(5)(vi)-Supervision of Prisoners.

61. On 2/15/16 for the 3:00 p.m. to 11:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 3:00 p.m., Cummings was laying naked on the floor pushing scattered food under the door. At 4:32 p.m., dinner was on the unit and was offered to Cummings. Per the meal monitoring tool, Cummings did not accept the meal tray or eat any food. [redacted] This was not noted in the one to one log book. There was no refusal form signed or progress note written. This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00. This is also a failure of facility staff to document all of Cummings' daily activity which constitutes a violation of 9 NYCRR §7003.3 (j)(5)(vi) Supervision of Prisoners. Per the documentation in the log book Cummings spent the entire shift laying on the bunk or the floor. During an interview with Commission staff, Dep [redacted] stated that Cummings was pacing back and forth and looked healthy. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners. Dep [redacted] stated that Cummings had her smock off and was pacing and she didn't recall seeing her oranges in the cell. Cummings "seemed out in space with a glazed looked on her face" and Dep [redacted] reported that she had been acting this way. Dep [redacted] reported that her prior contact with Cummings was escorting her to a visit and she "seemed off, not responding, and not following direction." On the 3:00 p.m. to 11:00 p.m. shift, there is no indication in the one to one log book that an RN was in to see Cummings. There is no indication that during this shift Cummings urinated which marked 32 hours without any observation of her urinating, a critical finding indicating possible renal failure that needed to be immediately reported to medical staff. The failure of facility staff to document all of Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3 (j)(5)(vi)-Supervision of Prisoners.

62. On 2/16/16 on the 11:00 p.m. to 7:00 a.m. shift, Cummings was supervised by Deputy [redacted] There was no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 4:45 a.m., Cummings was noted to be hyperventilating. There is no indication of any action taken by the deputy. At 5:25 a.m., the breakfast meal was served. Per the log book, the deputy could not open the pass thru as the door was stuck. At 5:37 a.m. the pass-through was

finally opened and her meal was served. At 5:57 a.m., Cummings was noted to eat dry cereal and drink juice. At 6:45 a.m., Cummings was observed laying on floor hyperventilating. There is no indication of any action taken for this. During an interview with Commission staff, Deputy [redacted] stated that she would have reported this hyperventilating to the sergeant but she does not recall if he came to the unit. Deputy [redacted] stated that Cummings ate more food that morning than she had seen her eat previously. Deputy [redacted] stated that the 6:45 a.m. episode of hyperventilating would have been relayed to the incoming staff. There is no indication of Cummings urinating. This indicated that Cummings had not been observed to urinate for 40 hours, a critical finding that Cummings was in renal failure and possible ketoacidosis with the observed hyperventilation. The failure of facility staff to document all of inmate Cummings' daily activity constitutes a violation of 9 NYCRR §7003.3(j)(5)(vi)-Supervision of Prisoners. Additionally, the Medical Review Board finds that deputies conducting supervision failed to make immediate notification to medical staff of multiple observations that indicated Cummings was suffering from acute illness.

63. On 2/16/16 on the 7:00 a.m. to 3:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. Cummings was observed lying on the floor naked with trash thrown all over the cell which Cummings refused to throw out. Upon review of the Constant Observation log book, there was no evidence that Cummings had cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2 (c). Cell Sanitation. This is a violation of NYS Correction Law Article 20 §500 – K Treatment of Inmates that applies Article 6 §137 (6)(b). At 7:30 a.m., the Delta Control Log Book indicated that Cummings was offered recreation but she refused. At 8:00 a.m., Cummings was noted to be kneeling by the door having a bowel movement. Upon review of the Constant Observation log book, there was no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2 (c)-Cell Sanitation. At 8:45 a.m., Cummings was noted to be lying on the bunk with a blanket. At 9:15 a.m., Cummings was standing at the door. At 10:00 a.m., Cummings was observed pushing garbage under the door. When Cummings was asked to get the garbage to throw out, Cummings laid back on the floor. At 11:30 a.m., Cummings was offered a lunch tray and pushed it back out of the cell. At 11:45 a.m., Cummings was observed smearing wet cereal from her breakfast tray on the floor. At 12:00 p.m., Cummings was observed playing in the garbage and food in the cell on the floor. At 12:30 p.m., Cummings was observed smashing cereal all over her body and the floor. At 12:45 p.m., Cummings was heard screaming "I have a sister." At 12:50 p.m., the Delta Control Log Book noted that Cummings refused to go to City Court. At 2:15 p.m., Cummings was observed drinking milk. [redacted] At 2:50 p.m., Cummings was observed urinating on the floor and did not responding to verbal communication. During an interview with Commission staff, Deputy [redacted] stated that Cummings had been "going downhill." Deputy [redacted] attempted to engage and encourage Cummings to eat. Deputy [redacted] reported that when mental health came in to see her she covered her head with a blanket and would not engage them. On the 7:00 a.m. to 3:00 p.m. shift, there was no indication in the one to one log book that an RN was in to see Cummings to assess her or review the meal monitoring tool.

64. [redacted] The Medical Review Board finds that the continued lack of assessments, follow ups, and overall failure to treat Cummings' fractured humerus, documented mental status decompensation, and observed signs of renal failure constitutes gross negligence of the Erie County Holding Center's medical staff.

65. [redacted]

66. [redacted] This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01 as medication compliance can be viewed by any provider on the electronic system and does not require medical to update.

67. [redacted] The Medical Review Board opines that this obvious decline in functioning should have been addressed immediately and medical staff should have been notified immediately. There is no evidence that any medical provider was consulted with or notified of Cummings' physical condition. There is no evidence that the psychiatrist was consulted regarding Cummings' mental state and decline of functionality. Upon review of the Constant Observation log book, there is no evidence that Cummings cleaned her cell or that any other staff cleaned the cell of the food and urine. This is a violation of 9 NYCRR §7015.2 (c). Cell Sanitation.

In a response to the Commission's preliminary report dated 5/30/18, the Erie County Attorney indicated that there was insufficient evidence to support that Cummings cell was not cleaned. Per the Commission's review of the Constant Observation log book for that date 2/16/16, there were no entries regarding any cell cleaning. Addtionally, FNP [redacted] *clinical record specifically stated "cell is deplorable".*

68. [redacted] He stated that the facility can get information from outside sources and try to incorporate the families in the care. FNP [redacted] stated that the 9Z2 beds are the only options for the county and if there is a medical reason for the behavior, medical staff can send the inmate to the emergency room. [redacted] He stated that medical staff would get the request and follow the instructions. FNP [redacted] stated that there is no way to confirm if the note on the desktop is received or read by medical staff. He did state that if the request was not completed, they have the option to call medical staff or resend the note. [redacted] FNP [redacted] stated that he does not get the minutes from the Interdisciplinary Team Meeting. FNP [redacted] stated that the forensic staff meets two times a week with the psychiatrist, NP, and counseling staff. [redacted] The Medical Review Board finds that the FNP's decision that Cummings' condition was drug related without consulting a psychiatrist or medical provider to rule out a potential medical condition compounded the progressing medical crisis that ultimately led to her death. The Medical Review Board finds that there was a systemic lack of communication and coordination of care in the Forensic Mental Health Department. The request by Dr. [redacted] for a medical evaluation was never completed and was attempted by an RN, a person wholly underqualified given Cummings' deteriorating status. The mental health providers were not aware that Cummings was not taking her prescribed medications. The Interdisciplinary Team Meeting minutes did not reflect any other information on Cummings other than her waiting for a 9Z2 (forensic mental health) bed and seem to serve little to no valuable function in their present format to address inmate's serious health needs. The NP was not aware that Dr. [redacted] believed this could be a medical issue and did not report his findings to her. Dr. [redacted] did not follow through with her request for a medical evaluation and despite getting the Interdisciplinary Team Meeting minutes, did not note that the report indicated that Cummings was awaiting a 9Z2 bed per her order with no mention of a medical evaluation. Additionally, the Medical Review Board finds it unconscionable that for a six-day period, Cummings was maintained on constant observation status, with documented observations of her failing to eat, failing to urinate, mentally decompensating without any immediate referrals to the jail physician and or reports to jail administration. As the Sheriff of Erie County holds the ultimate responsibility to safely keep all inmates in his custody, the Medical Review Board finds that the collective neglect and failures to provide proper care to Cummings is a violation of NYS Correctional Law §500-c (4).

69. On 2/16/16 on the 3:00 p.m. to 11:00 p.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one which is a violation of 9 NYCRR §7003.3(j)(5)(i)-Supervision of Prisoners. At 3:15 p.m., Cummings was observed lying on her bunk under the blanket. At 4:35 p.m., Cummings' dinner meal was placed on the pass-through slot. At 5:25 p.m., Cummings tray was removed untouched however she did drink her juice. At 6:45 p.m., Cummings was trying to put on her pants while lying on the floor. Cummings did get her uniform on and was laying on the bunk, but her pants appeared too small. Cummings was observed either lying on the floor or the bunk the entire shift. On the 3:00 p.m. to 11:00 p.m. shift, there was no indication in

the one to one observation log book that an RN was in to see Cummings to assess her or review the meal monitoring tool. There was documentation in the Delta Female Control Book that the nurse was on the unit for medications at 7:50 p.m. without indication of any refusals. There was no documentation in the Delta Female 2 to 1 log book that the LPN delivered medications for Cummings. [redacted] This is a violation of Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00. Deputy [redacted] recalled Cummings spoke very little, but that she had water and a mattress in her cell. Cummings was noted to moan but never voiced complaints. Deputy [redacted] was unable to recall if Cummings stood at all during that shift.

70. On 2/17/16 on the 11:00 p.m. to 7:00 a.m. shift, Cummings was supervised by Deputy [redacted] There is no indication of the reason for the one to one observation which is a violation of 9 NYCRR §7003.3 (j)(5)(i) Supervision of Prisoners. Cummings was again observed to be naked at 11:00 p.m. She was then observed either lying on the floor or her bunk crying until 12:47 a.m. Deputy [redacted] called the sergeant and advised that there was something wrong with Cummings and requested to have the cell cleaned. At 12:47 a.m., Sergeant [redacted] and Deputy [redacted] along with maintenance arrived to clean Cummings' cell. When Sergeant [redacted] arrived, Cummings was lying on the floor in her cell. Cummings was asked to stand to have the mechanical restraints applied and appeared to have difficulty attempting to stand. A wheelchair was then obtained for Cummings and she attempted to get into the wheelchair per Sergeant [redacted] but was unable to stand. Medical staff was then notified. Cummings was assisted into the wheelchair by the deputies. Cummings appeared to be confused. [redacted] Deputy [redacted] transported Cummings via wheelchair to medical. Deputy [redacted] then remained in the hallway and did not hear anything being said. [redacted] A known medical problem that was neglected for over 14 days.

71. [redacted]

[redacted]

72. During an interview with Commission staff, Deputy [redacted] stated that Cummings appeared to have lost all her strength. Deputy [redacted] stated that there was a change noted in Cummings since she had supervised her on the 7:00 a.m. to 3:00 p.m. shift and this was why she called for the sergeant. During an interview with Commission staff, Sergeant [redacted] was unable to recall the condition of the cell but did recall food thrown around in the cell. Per Sergeant [redacted] the plan was that Cummings would be placed in mechanical restraints and stay on her bunk while the cell was cleaned if she was not willing to leave the cell. During an interview with Commission staff, Deputy [redacted] stated that he was there to assist with cleaning the cell. Deputy [redacted] could not recall the condition of the cell.

73. [redacted] Cummings was on hospital watch until 2/17/16 at 4:30 p.m. when she was released from the custody of the Erie County Sheriff's Office.

74. During an interview with Chief [redacted] who was the Chief of Operation at the Erie County Holding Center, he reported that he did get copied on the Interdisciplinary Reports however, he had never seen Cummings. Chief [redacted] stated that he does tour the facility but not all areas. Chief [redacted] stated that water deprivation orders are issued by the watch commander and deprivation orders are written. He did not recall any deprivation orders for Cummings. When asked if he was aware of Cummings' condition and request for transfer to ECMC's 9Z2 unit, he stated that he was not. Chief [redacted] stated that administration can inquire about placement but already understands that there is a long wait for beds. Chief [redacted] did not recall anyone voicing concerns about Cummings.

75. From 2/12/16 until 2/16/16, the medical department violated Erie County Department of Health (ECDOH) Correctional Health (CH) Meal Monitoring ECDOH CH-06.10.00 (Policy #12-10-00) and Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01. Cummings was not seen daily for vital signs or assessment and there is no indication that Cummings was seen by a nurse other than to refuse medications. During the five days that Cummings was on meal monitoring there is no evidence in the Delta Control log book or the Delta Female one to one log book of an RN coming to see Cummings for an assessment, weight, intake, or referral to a provider. There is no evidence that the meal monitoring tool was reviewed by the RN.

In a response to the Commission's preliminary report dated 5/30/18, the Erie County Attorney indicated that per policy 05-03-01 vital signs are not required daily for meal monitoring, as the policy states "the nurse will review the meal monitoring form daily and document the inmate's medical assessment…". ECDOH CH-06.10.00 (Policy #12-10-

00) requires the inmate be "scheduled for daily weights, vital signs and a nursing assessment of orientation and mental status". Both policies were provided for the Commission's review with no indication that either were not applicable. Additionally, the requirement per policy 05-03-01 for a "medical assessment" to be conducted daily for an inmate under a meal monitoring study would, with a reasonable amount of medical certainty, expect to include a recording of vital signs.

76. From 2/12/16 until 2/16/16, the Interdisciplinary Team meeting was held and violated Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01 which states that "the interdisciplinary team will discuss each inmate being followed for meal monitoring of any concern or change in condition.

77. [redacted] From 2/5/16 until 2/16/16, there are no refusal forms documented in the medical record. The medication was refused and there is no evidence of a progress note in the medical record or of the doctor or mental health being notified. This information was not noted at the Interdisciplinary Team Meetings. There is no evidence of follow up with medication compliance from the mental health staff. Per Erie County Forensic Mental Health Services Standard Operating Procedures Policy: Forensic Mental Health: Refusal of Active Case Treatment/Medication Policy #11 Refusal of Medication Procedure 5- "in circumstances where the inmate provides conflicting information regarding medication compliance, compared to Correctional Health, FMP QMHP will review MAR/EMAR to address validity/accuracy of information." There is no evidence this review was ever completed as all mental health providers stated that they were unaware that Cummings had refused all doses of medications. Cummings was to receive a total of 12 doses of medication and there is no evidence that she received any medication during this time period.

78. Commission staff interviewed facility staff and reviewed the Constant Observation logbook entries from 2/12/16 until 2/16/16 for Cummings and noted that there was only one documented entry within the logbook that Cummings was offered, refused, or afforded access to a hot shower while she was on Constant Observation. Cummings was entitled to receive five showers during this time. The denial of access to hot showers constitutes a violation of 9 NYCRR §7005.2. (b) Showers.

In a response to the Commission's preliminary report dated 5/30/18, the Erie County Attorney indicated that Cummings should have only been afforded access to a hot shower three times during this period as she was housed in special housing and 9 NYCRR §7005.2 states, "hot showers shall be made available to all prisoners confined in special housing….at least three times per week." The intent of this standard is to ensure a minimal access to showers is provided not a maximum and should not serve as an impediment for prisoners to maintain proper hygiene.

79. The matter of India Cummings death was referred to the Erie County District Attorney's Office for review. The District Attorney's Office closed out their review as of September 2017 with no grand jury review ordered or any charges filed.

80. The MRB disagrees with the Erie County Medical Examiner's conclusion that the cause and manner of Ms. Cummings' death were both "Undetermined." India Cummings was diagnosed as suffering from terminal acute renal failure, rhabdomyolysis, dehydration,

thrombosis of leg veins and a poorly healing fracture of the humerus on admission to Buffalo General Hospital. She had been incarcerated at the Erie County Holding Cell for 16 days. Autopsy showed that the immediate cause of her death was a massive pulmonary embolism that occluded blood flow to both lungs. An examination of the microscopic autopsy slides and the circumstances of death establish that the embolus had detached from lower leg thrombosed veins and that it had developed after she was admitted to the ECHC. A brief medical examination at the Erie County Medical Center Emergency Room on the day of incarceration found that she had incurred a comminuted spiral Holstein-Lewis fracture of the left distal humerus consistent with her statement to the treating doctor that she felt her arm break as it was being pulled by a Lackawanna Police Officer who was restraining her. She was given a brace by the ER doctor but received no follow-up care at ECHC as her medical condition was observed to deteriorate. Therefore, the MRB has concluded that the cause of her death was a massive pulmonary embolism resulting from acute renal failure, rhabdomyolysis, dehydration and fracture of the humerus; and that the manner of her death was homicide by medical neglect.

ACTIONS REQUIRED:

TO THE OFFICE OF THE SHERIFF OF ERIE COUNTY:

1. The Sheriff shall take notice of the Medical Review Board's findings and recommendations in the report herein and commence comprehensive and systematic reviews of all Holding Center operations to assure that inmates are capable of being safely kept in accordance with Correction Law §500-c. (4). A report of corrective actions to be taken shall be provided to the Medical Review Board.

2. The Sheriff shall conduct a review of policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR §7003.3-Supervision of Prisoners regarding the documentation of reasons for increased supervision and the documentation of inmate behavior and activity when increased supervision is being provided.

3. The Sheriff shall conduct a review of policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR Part 7005 Prisoner Personal Hygiene regarding deprivation of inmate clothing and providing access to showers when on constant supervision status.

4. The Sheriff shall conduct a review of policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR §7013.9-Classification to assure that a proper review of classification occurs after an inmate is involved in a serious incident or exhibits adjustment problems that threaten the inmate's safety of the safety, security, or good order of the facility.

5. The Sheriff shall review the facility's policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR Part 7015 Sanitation and review why on multiple occasions Cummings cell was not cleaned of trash and food items.

6. The Sheriff shall review the facility's policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR Part 7022 Reportable Incidents and review why Cummings' assault incident on 2/3/16 was not reported to SCOC within the required reporting guidelines.

7. The Sheriff shall review the facility's policy and procedure and take administrative action to assure that staff are in compliance with 9 NYCRR Part 7040 Maximum Facility Capacity in regards to failing to replace Cummings damaged mattress and her prolonged deprivation of water absent any review or accountability by supervisors.

8. The Sheriff will develop a policy and procedure for all staff regarding water deprivation for inmates and will document that training has been completed with all staff regarding said policy.

TO THE COMMISSIONER OF ERIE COUNTY HEALTH DEPARTMENT AND THE JAIL PHYSICIAN:

1. The Commissioner and Jail Physician shall take note of the Medical Review Board's findings herein and commence a comprehensive review of the multiple failures of the medical staff including failures to pursue additional attempts to complete a medical assessment, failure to refer Cummings to a higher level of care, failures to provide adequate nursing assessments on multiple occasions, failures to order needed physician follow ups, overall failure to treat her fractured humerus, and failure to address observed signs of renal failure that constituted grossly negligent care and led to her preventable death. A thorough report of findings and corrective actions to be taken shall be provided to the Medical Review Board for further review.

2. The Commissioner and Jail Physician shall conduct a review of Cummings's intake medical screening and ascertain why an emergent mental health referral was not made to ECMC on Cummings given her documented altered mental status.

3. The Commissioner and Jail Physician shall conduct a review of Cummings' intake physical by NP J.C. who failed to document a thorough exam of Cummings' arm injury, failed to assure Cummings received prescribed medications, and failed to assure for proper follow up. Administrative action should be taken if found to be in violation of policy and procedure.

4. The Commissioner and Jail Physician shall review the facility's policy and procedure and take administrative action to assure that all medical staff are in compliance with 9 NYCRR Part 7010 Health Services in that a prompt screening is provided to assure serious illnesses or injuries are identified and treated.

5. The Commissioner and Jail Physician will assure training for all medical providers on the policy Erie County Department of Health (ECDOH) Correctional Health (CH) Initial Medical and Mental Health Screening – ECDOH CH-05.01.00 effective 09/10/10.

6. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Sheriff's Office Policy and Procedure Correctional Health Division Medication Management Medication Administration ECSO CHD: 11-01-00.

7. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Department of Health (ECDOH) Correctional Health (CH) Medication Delivery System ECDOH CH-06.04.00.

8. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Department of Health (ECDOH) Correctional Health (CH) Refusal of Care ECDOC CH-02-09-00 (Policy #12-07-00).

9. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Hunger Strike ECSO CHD:05-07-00.

10. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Department of Health (ECDOH) Correctional Health (CH) Meal Monitoring ECDOH CH-06.10.00 (Policy #12-10-00).

11. The Commissioner and Jail Physician will assure training for all medical providers on Erie County Sheriff's Office Policy and Procedure Correctional Health Division Inmate Care and Access Meal Monitoring ECSO CHD:05-03-01.

TO THE DIRECTOR, OF ERIE COUNTY FORENSIC MENTAL HEALTH SERVICES

1. The Director will take note of the Medical Review Board's findings herein and commence a comprehensive review of the multiple failures of the psychiatric providers and mental health staff to recognize, assess, and properly obtain emergency psychiatric care for Cummings florid psychosis. Additionally, the Medical Review Board requests that the Erie County Mental Health Department commence a comprehensive review of all crisis level services as the Board has found an alarming pattern of fatal incidents with justice involved patients in Erie County. A thorough report of findings and corrective actions to be taken shall be provided to the Medical Review Board for further review.

2. The Director will review the function of the Interdisciplinary Team and assure that adequate documentation on the report is made and assure that all Medical and Forensic Mental Health providers have access to the report. Additionally, the Interdisciplinary Team should include both a psychiatric and medical provider.

3. The Director will review with process of obtaining medical evaluations requested by Forensic Mental Health staff and develop a policy to assure completion of requests and availability of such evaluations.

4. The Director shall conduct a comprehensive review of the 730 examination order process and ascertain why an expedited review was not completed on Cummings despite requests from two separate magistrates.

5. The Director shall conduct an investigation into the conduct of LMHC [redacted] who approved Cummings for general population housing despite documenting her altered mental status and failure to properly inform the Erie County Holding Center staff of her condition. Administrative action should be taken if found to be in violation of policy and

procedure.

6. The Director shall conduct an investigation into the conduct of Mental Health Specialist [redacted] who failed to make an immediate psychiatric referral on Cummings despite documenting that Cummings was not capable of signing a release of her medical information due to her mental status. Administrative action should be taken if found to be in violation of policy and procedure.

7. The Director shall conduct an investigation into the conduct of FNP [redacted] who failed to make an immediate notification to a physician regarding Cummings' deteriorating physical condition and failed to consult with psychiatry or a physician when determining that Cummings' mental status was possibly drug related. Administrative action should be taken if found to be in violation of policy and procedure.

8. The Director shall conduct an investigation into the conduct of Dr. [redacted] who failed to order an immediate psychiatric hospitalization of a patient in obvious crisis and failed to engage in a physician to physician consultation regarding the possible underlying medical causes of Cummings' progressively deteriorating health. Administrative action should be taken if found to be in violation of policy and procedure.

TO THE ERIE COUNTY MEDICAL EXAMINER:

That the Erie County Medical Examiner review the forensic pathology of this case in light of the findings of the Medical Review Board with an eye toward a restatement of the cause of death to better reflect the circumstances and the autopsy findings that Cummings death was attributed to traumatic injury received during her arrest with a prolonged period of continual medical neglect and therefore should be ruled as homicide due to medical neglect.

TO THE CHAIR OF THE ERIE COUNTY LEGISLATURE:

That the Erie County Legislature take official notice of the findings of the Medical Review Board in the case cited herein and the findings of previous matters that the Board has reported on to address the alarming pattern of fatal events that have occurred in Erie County with justice involved individuals who are in mental health crisis. A comprehensive review and services plan should be commenced by the county.

TO THE ASSISTANT ATTORNEY GENERAL FOR CIVIL RIGHTS, U.S. DEPARTMENT OF JUSTICE:

That the Assistant Attorney General for Civil Rights take official notice of the findings of the Medical Review Board in the case cited herein and initiate both individual criminal civil rights investigations and a CRIPA investigation into the Erie County Sheriff's Office confinement and treatment of India Cummings.

WITNESS, HONORABLE THOMAS LOUGHREN, Commissioner, NYS Commission of Correction, Alfred E. Smith State Office Building, 80 South Swan Street, 12th Floor, in the City of Albany, New York 12210 on this 26th day of June, 2018.

Thomas Loughren

THOMAS LOUGHREN
Commissioner & Chair
Medical Review Board

TL:DC:tlc
06/2018